



The Torch

The official newsletter for Indiana state employees

2016 BENEFITS OPEN ENROLLMENT

OCT. 28 - NOV. 18, 2015 (by NOON EST)

This *special edition* is dedicated to 2016 Open Enrollment. Please review all the enclosed information concerning your health care coverage. During this period, you can choose to make additions or changes to your benefit selections. All open enrollment communications including carrier information, rates and plan summaries, are posted on the State Personnel Department’s website: www.in.gov/spd/openenrollment. Also SPD will release the Open Enrollment 2016 booklet on Oct. 27 via email and on the website. **This Open Enrollment information does not apply to conservation officers, excise officers, Indiana State Police plan participants, temporary employees or contractors.**

Don't forget to get your flu shot!

Kroger pharmacists are hosting a flu shot clinics at many state facilities across Indiana. Visit our website to see a list of upcoming clinics. If you do not carry State insurance, the cost is \$20 payable by cash or check. **Please Note:** if you plan to bring a child under the age of 11, it is necessary to have a written prescription from the doctor or a pharmacist to administer a flu vaccine. Since preventive care services are covered by the health plan at 100 percent, employees with the state’s health plan and their eligible dependents should get vaccinated.

You must bring your Anthem ID card and a completed waiver prior to receiving the vaccination:

- [Inactivated shot consent form](#) - **Learn more**
- [Live nasal vaccine consent form](#)

Kroger Pharmacies are also administering vaccines at participating retail locations. Vaccinations may also be administered at your doctor’s office, retail pharmacy or nearby walk-in clinic. Even at any of these locations, the state’s health plan covers 100 percent of the cost, if you carry state insurance.

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The Torch is published monthly by the State Personnel Department and is available online at www.in.gov/spd

Got a story?

Submit your story ideas to: spdcommunications@spd.in.gov

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Checklist

Check the list as you go through the process

For 2016, there are new rates for the medical and dental plans, as well as a new dental provider. A number of resources are available to help you estimate your 2016 expenses, compare plans and become a more informed consumer.

Use this checklist to help guide you through the steps to a successful Open Enrollment:

- Educate yourself about changes occurring Jan. 1, 2016.
- Access your HR PeopleSoft account.
- Confirm or update your personal information including your home and/or mailing address, e-mail address, phone number and ethnic group.
- If you wish to drop your insurance coverage you will need to select waive.
- If you are eligible for the 2016 Wellness CDHP you will need to select this option to enroll in the plan if you were not covered under the 2015 Wellness CDHP.
- If you were enrolled in the 2015 Wellness CDHP, but do not qualify for the 2016 Wellness CDHP your plan will default to CDHP 1 unless you make a new selection.
- Review your eligible dependents and beneficiaries.
 - You need to enroll all eligible dependents in each benefit plan you choose.
 - Remove all ineligible dependents from all of your benefit plans.
 - Update personal information for each dependent and/or beneficiary
 - Add your dependent social security numbers.
 - For dependent/beneficiary name changes, please contact the Benefits Hotline at 317-232-1167 or toll free at 877-248-0007 (if outside of the Indianapolis area).
- Check your current elections or make new elections. It is important that you review the dependents enrolled on each of your plans.
- If you have a Health Savings Account, you will need to enter your annual contribution amount.
- If you have a Flexible Spending Account, you will need to re-elect or re-state your annual contribution amount.
- Accept or decline the Non-Tobacco Use Agreement for 2016.
- Remember to print an **Election Summary** after you have submitted your elections for your records.



[Read more on page 12 about Castlight](#)

Dental coverage

New dental provider for 2016

State Personnel is pleased to announce that as of January 1, Anthem will be the new Dental provider. If you are currently enrolled in dental, your coverage will automatically transfer to Anthem. However, if you wish to enroll, change your level of coverage or change your dental dependents, you will need to actively make these selections within your Open Enrollment event.

In addition to the insurance provider change, the state is excited to announce that the orthodontic services benefit will be increasing. The new lifetime maximum for orthodontic services will be \$1,500 per eligible person.

Anthem Dental Complete will continue to provide 100 percent diagnostic and preventive coverage, as long as an in-network dentist is used. The plan also covers 100 percent of emergency palliative treatment (used to temporarily relieve pain), x-rays and sealants (to prevent decay of pits and fissures of permanent back teeth). There are limits to the coverage of sealants, however, so check with Anthem before agreeing to the treatment. You can save money by using an in-network dentist. To find an in-network dentist please visit Anthem.com and search dentist within the Anthem Dental Complete network.

Please be aware that the dental rates have changed slightly from last year. Below is a breakdown of the cost.

Dental	2016 Bi-Weekly Rate
Single	\$1.32
Family	\$3.42

- [View 2016 Anthem Dental Benefits Summary](#)

Know your health plan options and including the 2016 changes

The State is again offering four statewide medical plans for 2016: Wellness Consumer-Driven Health Plan (Wellness CDHP), Consumer-Driven Health Plan 1 (CDHP1), Consumer-Driven Health Plan 2 (CDHP2) and Traditional Preferred Provider Organization (PPO). All four available plans are in the **Blue Access PPO network** with Anthem and have a prescription drug plan through Express Scripts. Each plan has differences in premium costs, deductibles and out-of-pocket maximums.

Please note: in order to be eligible to enroll in the 2016 Wellness CDHP you must have attained Silver Status in HumanaVitality by August 31, 2015. If you qualified for the Wellness CDHP and wish to enroll in the plan for 2016, you must select this option within your Open Enrollment event. You will **not be automatically enrolled** in the plan unless you were enrolled in the Wellness Plan for the 2015 plan year. If you were enrolled in the 2015 Wellness CDHP but do not qualify for the 2016 Wellness CDHP your coverage will automatically be switched to the CDHP 1, unless you actively elect another plan.

Here are the differences at a glance:

	Wellness CDHP	CDHP 1	CDHP 2	Traditional PPO
Deductible				
Single	\$2,500	\$2,500	\$1,500	\$750 / \$1,500
Family	\$5,000	\$5,000	\$3,000	\$1,500 / \$3,000
Out-of-Pocket Maximum				
Single	\$4,000	\$4,000	\$3,000	\$3,000 / \$6,000
Family	\$8,000	\$8,000	\$6,000	\$6,000 / \$12,000
-Individual Embedded	\$6,850	\$6,850	N/A	N/A
Co-Insurance				
In-Network	20%	20%	20%	30%
Out-of-Network	40%	40%	40%	50%

Family Out-Of-Pocket Change for Wellness CDHP and CDHP 1

One significant change in the plans for this year is the addition of an individual embedded out-of-pocket maximum for the family Wellness CDHP and CDHP 1. The individual embedded out-of-pocket maximum will save families money by limiting the cost spent on any one person to \$6,850. Once a family member meets the individual embedded out-of-pocket maximum all claims incurred by that family member will be 100 percent paid by the plan. The other family members on the plan will continue to pay the coinsurance amounts for any claims they incur until the family out-of-pocket maximum of \$8,000 is obtained.

	Wellness CDHP		CDHP 1		CDHP 2		Traditional PPO	
	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)	Retail (30 day supply)	Mail (90 day supply)
Prescription drugs								
Preventive (mandated by the ACA)	\$0 no deductible	\$0 no deductible	\$0 no deductible	\$0 no deductible	\$0 no deductible	\$0 no deductible	\$0 no deductible	\$0 no deductible
Generic	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$10 copay	\$20 copay	\$20 copay	\$40 copay
Brand, Formulary	20% Min \$30 Max \$50	20% Min \$60 Max \$100	20% Min \$30 Max \$50	20% Min \$60 Max \$100	20% Min \$30 Max \$50	20% Min \$60 Max \$100	30% Min \$40 Max \$60	30% Min \$80 Max \$120
Brand, Non-formulary	40% Min \$50 Max \$70	40% Min \$100 Max \$140	40% Min \$50 Max \$70	40% Min \$100 Max \$140	40% Min \$50 Max \$70	40% Min \$100 Max \$140	50% Min \$70 Max \$90	50% Min \$140 Max \$180
Specialty	40% Min \$75, max \$150 (30 day supply)		40% Min \$75, max \$150 (30 day supply)		40% Min \$75, max \$150 (30 day supply)		50% Min \$100, max \$175 (30 day supply)	

Want to view an individual's out of pocket example? [Click here](#).

State continues to contribute to Health Savings Account

The State will continue to contribute approximately 39 percent or more of the Consumer-Driven Health Plan (CDHP) annual deductible to your Health Savings Account (HSA) in 2016 depending on what plan you choose. The initial contribution will be made on the first checks in January.

Employees enrolled in a CDHP effective from Jan. 1, 2016, through June 1, 2016, will receive the full pre-fund amount. CDHPs effective after June 2, 2016, but before Dec. 2, 2016, will receive one-half of the initial contribution. The initial pre-fund contribution is based on the coverage type (single/family) that is effective Jan. 1, 2016.

If you have an active HSA with The HSA Authority at Old National Bank and wish to continue receiving the State’s contributions in 2016, you do not need to open a new HSA account.

If you wish to change your contribution to your account or begin contributing for 2016, you need to access your PeopleSoft record and enter your desired contribution. **If you do not change your HSA contribution, it will not carry over for the 2016 plan year.**

If you are electing to participate in a HSA for the first time in 2016, you must edit the online HSA option in PeopleSoft and choose the HSA that corresponds to your medical CDHP election in order to receive the state’s contribution. In addition to electing the HSA option, you will need to

- May not be enrolled in Medicare, Medicaid, HIP or Tricare;
- Must not have used VA benefits for anything other than preventative services in the past three months.

To open your HSA, link to The HSA

HSA Account	Coverage	Initial Contribution	Bi-Weekly Contribution	Monthly Contribution	Maximum Annual ER Contribution
Wellness HSA	Single	\$625.56	\$24.06	\$52.13	\$1,251.12
	Family	\$1,251.12	\$48.12	\$104.26	\$2,502.24
HSA 1	Single	\$500.76	\$19.26	\$41.73	\$1,001.52
	Family	\$1,001.52	\$38.52	\$83.46	\$2,003.04
HSA 2	Single	\$299.52	\$11.52	\$24.96	\$599.04
	Family	\$599.04	\$23.04	\$49.92	\$1,198.08

open an HSA account with The HSA Authority before Jan. 1, 2016.

As a reminder, to be eligible for an HSA you:

- Must be currently enrolled in an HSA-qualified health plan;
- May not be enrolled in any other non-HSA qualified health plan;
- May not have, or be eligible to use, a general purpose flexible spending account (FSA);
- Cannot be claimed as a dependent on another person’s tax return;

Authority’s website from PeopleSoft on your HSA election page, or go directly to www.theHSAauthority.com and click on the “Enroll Now” button. The first page of this online session says: If you have been instructed by your employer to visit this site to open your HSA, click this button and insert your employer code below. Enter **100366** in the “employer code” and it will begin the state application.

You will need the following information to complete the HSA application online:

1. Driver’s license
2. Social Security number, date of birth and address for your beneficiaries
3. Social Security number, date of birth and address for your authorized signer (if selected)
4. Security passwords for you and your authorized signer (based on the answer to one of the five questions you select during the application process)

HSAs have a maximum contribution limit



Contributions are allowed up to the maximum statutory limit. The maximum annual contribution for 2016 is \$3,350 for self-only policies and \$6,750 for family policies. Individuals age 55 and over may make an additional catch up contribution of up to \$1,000 in 2016.

Combined household contributions cannot exceed the family limit. The maximum includes the state’s contributions and any other contributions to your HSA.

FSA's can provide tax-free help for qualified medical expenses with no administration fee in 2016

A Flexible Spending Account (FSA) provides another opportunity for you to better control your health care dollars. By tucking away pre-tax dollars from your paycheck, you have an account that's dedicated for the reimbursement of qualified medical, vision and dental expenses.



Medical Care FSA.

In addition, the bi-weekly employee administration fee is being paid by the State during the 2016 plan year, providing you with even more opportunities to save. The State's FSA program is administered through Key Benefits Administrators. All FSAs offered by the state have a use-it-or-lose-it rule. Money left at the end of the plan year is not rolled over or reimbursed, so plan carefully.

There are three types of FSAs: Medical Care, Limited Purpose Medical Care and Dependent Care. Medical Care and Limited Purpose Medical Care FSA accounts allow employees to use pre-tax dollars to cover health care costs for medical, dental, vision, hearing and other out-of-pocket expenses not paid by insurance.

For 2016, the maximum annual contribution for the Medical Care and Limited Purpose FSAs is \$2,500.

A Limited Purpose FSA may only be used for dental, vision and preventive care expenses until the minimum deductible of a CDHP is met (\$1,300 for single and \$2,600 for family, per federal regulations). Once the minimum deductible is met, the Limited Purpose FSA can be used as a

If you are enrolled in a CDHP/HSA, your FSA will automatically become a Limited Purpose FSA. You do not need to meet the minimum deductible to use the funds in your Limited Purpose FSA for dental and vision expenses. You can pay for dental and vision expenses from your Limited Purpose FSA at any point during the year.

A Dependent Care FSA is used to pay for dependent care services, such as preschool, summer day camp, before or after school programs and child or elder daycare. Dependent care expenses do not include medical expenses and therefore can be used even if you participate in a HSA.

Dependent Care FSAs are not front-loaded. Portions of your biweekly pay are put into a pre-tax account to pay for eligible dependent care costs throughout the year. Currently, the maximum annual contribution amount for the Dependent Care FSA is \$5,000 (\$2,500 if married and filing separate tax returns).

- [View more information and download enrollment information packets.](#)

Qualifying events allow for changes

After noon (EST) on Wednesday, Nov. 18, you will not be able to make changes to your benefits. This means you must be certain you have elected the coverage that is right for you and added all eligible dependents who you wish to cover to all plans (health, vision and dental). After Open Enrollment, you can only make changes in conjunction with a qualifying event.

Qualifying events are regulated and defined by the IRS. Examples include:

- Changes in your legal marital status (marriage, divorce, separation, annulment or death of spouse).
- Changes in the number of dependents (birth, adoption, placement for adoption or death).
- Changes in employment status for you or your spouse, such as termination of or change in employment, a strike or lockout, or the start or end of an unpaid leave of absence.
- Changes in dependent eligibility status (such as attainment of limiting age).

If you do not report a qualifying event and complete any necessary paperwork within 30 calendar days from the date of the qualifying event, you will not be able to add dependents until the next open enrollment period. Please note that an ex-spouse is ineligible for coverage as of the day of divorce. It is important that you report ineligible dependents even if it is beyond the 30 day period to minimize recovery of claims.

Medicare, Medicaid and HIP disqualify you from having a Health Saving Account

The IRS established Health Savings Accounts as a method to provide individuals a tax advantage to offset their health care costs. In doing so, the IRS created eligibility criteria to qualify for the account. To be eligible for an HSA you:

- Must be currently enrolled in an HSA-qualified health plan;
- May not be enrolled in any other non-HSA qualified health plan;
- May not have, or be eligible to use, a general purpose flexible spending account (FSA);
- Cannot be claimed as a dependent on another person's tax return;
- May not be enrolled in Medicare, Medicaid, HIP or Tricare;
- Must not have used VA benefits for anything other than preventative services in the past three months.

Based on the above eligibility qualifications, enrolling in Medicare, Medicaid or HIP 2.0 will disqualify you from having contributions into a Health



Savings Account (HSA). Once enrolled in any of these plans, you may not receive or make any contributions into a HSA. For more information about HSAs please see IRS Publication 969 at www.irs.gov/pub/irs-pdf/p969.pdf.

Although you can no longer make contributions to your HSA once you are covered by Medicare, Medicaid or HIP 2.0 the money that has accumulated in your HSA from past years remains yours to spend, tax-free, on eligible expenses, including Medicare co-pays or deductibles,

vision expenses and dental expenses. If you are age 65 or over, you also have the option to withdraw the money for any purpose and pay only the income tax without penalty. The same rules also apply if you receive Social Security disability benefits and are enrolled in Medicare.

Please review the below information carefully as it relates to your eligibility to qualify for an HSA.

Medicare

If you elect to receive Social Security Benefits at age 62 or older, you will automatically be enrolled in Medicare Part A when you turn age 65. If you wish to participate in the HSA, you should decline to receive Social Security retirement benefits and waive Medicare Part A. Keep in mind that there are potential consequences if you choose to decline or postpone your enrollment. Additionally, if you decided not to take Medicare when you first qualify, please be advised that your Medicare Part A start date may backdate up to six months when you apply for Social Security benefits. Please carefully research all of your options before making your decision.

You can use funds in your HSA to pay for incurred eligible medical expenses for your dependents (as defined by the federal regulations), even if they are not covered under your medical plan, or have other coverage, such as Medicare. However, keep in mind that if your spouse is on Medicare, she/he is not eligible to contribute to an HSA in her/his name, regardless of whether or not she/he is covered on your medical plan.

Medicaid and HIP 2.0

According to IRS regulations, an individual who is enrolled in Medicaid is not eligible to make or receive

contributions into an HSA. There are tax consequences to both the individual and the employer, if the employer is also contributing to an HSA for the employee. Similar to Medicare, if your dependent(s) is/are covered by Medicaid but you are not, you may continue to receive contributions into your HSA. Eligibility is based on the subscriber/account holder.



Vision plan is to remain the same

The Anthem Vision plan and premiums will remain the same for 2016. Through Blue View Vision Select, you have access to a wide selection of experienced opticians. Many of these opticians are located in convenient retail locations and offer evening and weekend hours. To get the most cost savings, it is important to seek care from an in-network provider. To find out which opticians are in your network please visit Anthem.com or call Blue View Vision Select toll-free at (877)254-9443.

Under Blue View Vision, you are authorized to receive an eye exam every 12 months, frames every 24 months and contact lenses once every 12 months.

- [View 2016 Anthem Vision Benefits Summary](#)

Non-tobacco use incentive

The Non-Tobacco Use Incentive will not change for 2016

The Non-Tobacco Use Incentive is being offered again for the 2016 plan year. You can receive a \$35 reduction in your group health insurance bi-weekly premium by accepting the agreement during Open Enrollment. By accepting the incentive, you are agreeing to not use any form of tobacco products in 2016. This applies to employees who have never used tobacco products, employees who have refrained from using tobacco products in past years and to those employees who have decided to quit using tobacco products prior to Jan. 1, 2016. Keep in mind, by accepting the agreement you are agreeing to be subject to testing for nicotine at any time during the year. The Non-Tobacco Use Agreement must be completed each year online.

The Non-Tobacco Use Incentive is only available to employees who have enrolled in medical coverage. You will not have access to the agreement if



you waive medical coverage for plan year 2016. The reduction in your group health insurance bi-weekly premium only applies to your employee medical premium, and does not apply to your dental, vision or life insurance premiums.

If you accept the Non-Tobacco Use Agreement during Open Enrollment and later use tobacco, your employment will be terminated. The only exception to the job loss penalty is if you revoke the agreement by logging in to PeopleSoft and completing

the self-service process to change your agreement prior to the use of any tobacco product. If you need to revoke your agreement and are not sure how to complete the process in PeopleSoft, call the Benefits Hotline and a specialist will walk you through it. If you revoke the agreement you will be responsible for paying the value of the incentive you have received for the year. The \$910 is a great incentive, but it certainly isn't worth losing your job.

The Non-Tobacco Use Incentive does not carry over from year-to-year. If you would like to participate in 2016 you must access your PeopleSoft record and accept the agreement.

Anyone interested in getting help to become tobacco free, log onto or call Quit Now Indiana: www.quitnowindiana.com or call 1-800-QUIT-NOW (1-800-784-8669). This is a free service.

Dependents

Children are covered up to the end of the month they turn 26

Adult children may be covered under the State's medical, dental, vision and dependent life insurance plans until the end of the month of their 26th birthday. A dependent's last day of coverage will be the last day in the month in which they turn 26. Dependents will be offered COBRA when they lose eligibility. Spouses of adult children (deemed children-in-law) and grandchildren are not eligible for this coverage.

Disabled dependents can be enrolled in any of your desired plans during the Open Enrollment period if they have not exceeded the month in which they turn 26. Prior to your dependent turning 26-years-old, you must contact Anthem at 877-814-9709 to request to continue

your dependents coverage due to their disability. You must submit satisfactory evidence of the dependents disability and dependency to Anthem in accordance with Anthem's disabled dependent certification and recertification procedures. The plan requires periodic documentation after the child turns age 26.

Please note: In order for a disabled dependent to continue coverage past the month in which they turn 26 years of age, that dependent child must have been deemed disabled prior to age 19. If a dependent child was deemed disabled after age 19, they will not be eligible to continue coverage past the month they turn



age 26.

You must access PeopleSoft during open enrollment and edit your dependent information. Keep in mind, you will have to enroll your dependents on each plan (medical, dental, and vision) for which you desire coverage.

HIPAA

HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your, or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Hotline at 317-232-1167 (within Indianapolis) or toll free 1-877-248-0007 (outside the 317 area code).

Coverage

Dual coverage is not allowed under any plan

Dual coverage of the same individual is not allowed under the state's health, dental and vision benefit plans. For example, dual coverage by two state employees is not allowed, meaning that if both you and your spouse are state employees with insurance coverage (or one is a current employee and the other is a retiree), you may not cover each other on both plans or have the same children on family coverage. This also applies to parents of children who are not married to each other. You may each elect a single plan, one may carry family and the other may waive coverage, or one may carry family with the children and the other carry single coverage.

A second example occurs when an employee who has retired from one area of state employment begins active work in another state position. In this instance, you will have the choice to continue your retiree coverage and waive your active employee coverage, or vice versa. However, you will not be permitted to carry state retiree insurance and active state employee coverage simultaneously. Dual coverage is only permitted for dependent life.



Name change for Minnesota Life Insurance Company

Minnesota Life Insurance Company is in the process of rebranding their company name to Securian. The name change will not impact your coverage; however, please be aware that you may begin to see communication under the Securian name.

Notice

State plans provide creditable coverage

If you are Medicare-eligible, there are two important things you need to know about your current coverage and Medicare's prescription drug coverage.

First, Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare.

Second, the State's Third Party Administrator determined that the prescription drug coverage offered by Express Scripts is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

If you are considering joining Medicare's prescription drug coverage, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area.

For more information about Medicare's prescription drug coverage please visit: www.medicare.gov.

Effective dates

When do my changes take effect?

Health, dental, vision, Health Savings Account and Flexible Spending Account changes/enrollments will be effective January 1, 2016.

Deductions for health, dental and vision will begin:

- **Payroll A:** Dec. 16, 2015 (12 days at old plans & rates; 2 days for new plans & rates)
- **Payroll B:** Dec. 23, 2015 (5 days at old plans & rates; 9 days for new plans & rates)

Deductions for the Flexible Spending Accounts and Health Savings Accounts begin on the following dates:

- **Payroll A:** Jan. 13, 2016
- **Payroll B:** Jan. 6, 2016



Effective dates for Life insurance changes and enrollments will vary depending on which payroll you are in along with the date your deductions will begin.

Payroll A:

Effective: Jan. 3, 2016
Deduction: Dec. 30, 2015

Payroll B:

Effective: Jan. 10, 2016
Deduction: Jan. 6, 2016

Direct Bill

Effective: Jan. 1, 2016

PeopleSoft steps

Submit your Open Enrollment elections through PeopleSoft

You can access your Open Enrollment event 24 hours, seven days a week from Wednesday, Oct. 28 through noon Wednesday, Nov. 18 (EST). Keep in mind, you can access your Open Enrollment event from any computer that allows you access to PeopleSoft.

Helpful hints:

1. Your User ID is your first initial of your first name capitalized followed by the last six (6) digits of your PeopleSoft number. If you have forgotten your PeopleSoft number please contact your agency's Human Resources Department for assistance.
2. If you access the state network, the password used to log on to your computer can be used to log into PeopleSoft.
3. For password resets, network connectivity or issues accessing the website, please contact IOT Customer Service at (317) 234-HELP (4357) or Toll-Free at 1-800-382-1095, and follow the menu options.
4. When making your elections in PeopleSoft, do not use the BACK/FORWARD arrow buttons at the top of your web browser.
5. Keep in mind you must turn off your "pop-up blocker" in order to print your Benefit Election Summary.
6. For any benefit related questions please call the Benefits Hotline at 317-232-1167 or Toll-Free at 877-248-0007 (if outside of the 317 area code).



IMPORTANT: Once you are satisfied with your open enrollment elections, it is essential that you submit your elections and print a Benefit Election Summary for your records.

Remember, you can access PeopleSoft at any time during the year to review your benefits or update contact information. You may access PeopleSoft through any of the below links:

- <https://hr.gmis.in.gov/psp/hrprd/?cmd=login&languageCd=ENG&>
- <http://www.in.gov/spd> and click on the PeopleSoft HR link on the right side
- <http://myshare.in.gov/> and select the Oracle Human Resources link.

To view your current benefit elections, you need to login to PeopleSoft and follow these steps: Click on Self Service, Click on Benefits and Click on Benefit Summary. Your 2016 benefits will not be available to view until Jan. 1, 2016.

If you have questions about your elections, contact the Benefits Hotline, 7:30 a.m. to 5 p.m (EST) Monday through Friday. Call 317-232-1167 within Indianapolis area or 1-877-248-0007 toll-free outside Indianapolis

Support to help you achieve health goals

The State is committed to providing employees with helpful tools in order to achieve a more active and healthy population. All employees enrolled in an Anthem health plan receive special services in conjunction with the Anthem 360°



Health program. Anthem 360° Health provides you with support to help you achieve your health goals by working with you, your doctor and other health care professionals to assist you in improving your health.

FSA

Are there other ways to save besides a HSA?

Flexible Spending Accounts (FSA) provide another opportunity to set aside pre-tax dollars from each paycheck for reimbursement of qualified medical and/or dependent daycare expenses. The maximum contribution to a medical flexible spending account in 2016 is \$2,500 annually. This applies to both the medical FSA and the limited purpose medical FSA. The dependent care FSA will continue to have a \$5,000 annual contribution limit.

You must re-enroll in medical and dependent care FSAs each year if you wish to continue to participate. If you continue participation in the Medical FSA, do not discard the debit card from Key Benefit Administrators. New cards are not automatically issued each year.

For the 2016 plan year, the State will pay the bi-weekly administration fee. As a reminder, FSAs have a “use-it-or-lose-it” rule. Money left at the end of the plan year is not rolled over or reimbursed so plan carefully.

Representatives from the Anthem 360° program may contact you to help you reach your health goals. Visit www.anthem.com for more information.

Nurse Line

Nurse Line provides anytime, toll free access to nurses for answers to general health questions and guidance with health concerns. A nurse can help you understand your symptoms or explain medical treatments. Every caller receives credible, reliable information from a registered nurse.

The Nurse Line is available 24/7 by calling 1-888-279-5549.



Need help?

Help sessions are available

For 2016 plan summaries, rates, PeopleSoft instructions and other Open Enrollment information, please log onto [our website](#).

Help sessions are provided in the Indiana Government Center South [Training Room 31](#) throughout Open Enrollment for those needing assistance with entering elections and navigating through PeopleSoft. Hours are (EST):

- **Oct. 28 to Nov 6:** 8 a.m. to 3 p.m.
- **Nov. 9 to Nov 13:** 8 a.m. to 4 p.m.
- **Nov. 16 to Nov. 17:** 8 a.m. to 5 p.m.
- **Nov. 18:** 8 a.m. to noon

If you have specific questions about Open Enrollment not answered on the [State Personnel Department's website](#), call or e-mail a Benefits Specialist in State Personnel:

- 232-1167 (within Indianapolis)
- Toll free 1-877-248-0007 (outside the 317 area code)
- E-mail: SPDBenefits@spd.in.gov

Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The life insurance tier system is changing

But there are more opportunities to elect dependent life coverage

State Personnel is excited to announce that beginning this Open Enrollment, you may elect dependent life insurance without being enrolled in supplemental life. This change allows you the opportunity to elect dependent life insurance without enrolling in supplemental. Please keep in mind that you are still required to have basic life insurance to be eligible to apply for supplemental or dependent life.

Also, it is important to note that while child life insurance is guaranteed issue regardless of when the application is made, spouse life requires completing the Evidence of Insurability (EOI) process to acquire or increase the coverage level outside of your new hire election period.

During Open Enrollment, you will be able to decrease your coverage level or drop any of your life insurance plans. You may also update your beneficiary information and/or allocation amounts through your Open Enrollment event. All changes will be effective in January.

Outside of Open Enrollment you may acquire or make changes to your life insurance plans by completing the EOI process at any time throughout the year. Allowable changes include increasing your coverage level and/or adding an eligible spouse to your dependent life insurance plan. This process applies to all three life insurance plans sponsored by the state of Indiana (basic, supplemental and dependent life).

The EOI application can be completed



online at any time at www.LifeBenefits.com/SubmitEOI. On average the application takes 10 to 30 minutes to complete. Instructions on how to submit EOI through Securian can be found at www.in.gov/spd/2868.htm. Once submitted, Securian will review your application and inform both you and SPD Benefits of its decision. If approved, SPD Benefits will make the appropriate changes to your life insurance plans and start the premium deductions.

Please keep in mind, you may also make changes to your beneficiary information at any point during the year by accessing PeopleSoft self-service. Instruction on how to change your life insurance beneficiaries can be found at www.in.gov/spd/2868.htm. Please remember, you are the only one who can change your beneficiary information.

Reminder: Supplemental life insurance is offered to most employees in increments of \$10,000 up to and including \$500,000, regardless of salary level. Employees reaching age 65 or older on or before Dec. 31, 2015, will be limited to \$200,000 of supplemental life insurance coverage. Employees attaining age 65 during the plan year will automatically be reduced to \$200,000 of supplemental life insurance coverage and their payroll deductions adjusted accordingly.

Review and update your life insurance beneficiary information

Open Enrollment is a great time to review your current life insurance beneficiary information. It only takes a couple minutes to verify your beneficiary designations and update their contact information in your Open Enrollment event. By routinely checking this information you are assuring that you have allocated your life insurance benefits as desired since certain life events such as marriage, divorce birth or death may change how you would like your benefits paid out.

In addition to confirming your beneficiary allocation, you should also update their contact information. It is extremely important that PeopleSoft has the correct addresses and phone numbers for all of your beneficiaries. This information is used to identify and locate your designated beneficiaries if a claim was to be processed. Without updated contact information it may take a significantly longer period of time to pay out a claim.

Once you have designated your beneficiaries, it is a good idea for you to notify them of your policy and your decision to list them as a beneficiary. Providing policy information to your beneficiaries prior to a claim occurring makes a difficult situation easier to cope with especially when dealing with the financial aspect of the loss.

Note: All beneficiary changes made within your Open Enrollment event will take effect in early January based on which payroll you are in along with the date your deductions will begin.

The Employee Assistance Program (EAP) has been upgraded for 2016

As of January 1, 2016, you will have access to three free, confidential in-person counseling visits with a licensed therapist, per issue, per year when contacting the Employee Assistance Program (EAP). This enhancement will be available to all employees and their household members regardless of insurance coverage. Additionally, Anthem's EAP will continue to offer 24 hour, seven days a week phone and online access to an abundance of health, financial and lifestyle services from experts and professionals within their respective fields.

As a State employee you have access to the following private and confidential tools aimed at helping you balance your work and home life:

- **Counseling sessions.** Three face-to-face sessions, per issue, with a licensed therapist – no deductibles or copays effective January 1, 2016. If you need further assistance, your EAP can help you coordinate with available resource.
- **Assistance with legal and financial concerns,** including a 30-minute initial consultation, per issue, with a qualified attorney or financial advisor.
- **Dependent care referrals.** Locate child and eldercare providers using on-line tools or calling your EAP directly.
- **Convenience services.** Obtain resources and information on pet sitters, educational choices for you or your children, summer camp programs and much more.
- **Website – anthem.EAP.com.** Contains a comprehensive level of resource articles, self-assessments, audio and video material covering emotional well-being, health and wellness, the workplace, and life issues such as childcare, eldercare, adoption and education.
- **Smoking cessation.** Access telephonic tobacco cessation coaching for smoking and chewing, coaching support with weight management as it relates to the cessation program, 10-session online Living Free behavior change module and tobacco cessation tip sheets.
- **ID recovery and credit monitoring.** Assess your risk level and identify steps to resolve potential identity theft. Your EAP can help you complete any necessary paperwork, will report to consumer credit agencies for you, and negotiate with creditors to repair your debt history.
- **Member center.** Includes access to a listing of EAP providers in your preferred area and routine counseling referral service.



To access Anthem's EAP online resources please visit the website at www.AnthemEAP.com. From the homepage, click the Members Login button on the left-hand side of the page. The next page will ask you to enter your company name which is State of Indiana. Once you've hit the "Log In" button, all of these services are open to you. Free 24 hour, seven day a week access is available by calling (800) 223-7723. All of these resources are confidential and available to your dependents and members of your household.



Spend your healthcare dollars wisely

Castlight gives you the information you need to make smart health care decisions for you and your family. Using Castlight online or through the mobile app, you can:

- Compare nearby doctors, medical facilities, and health care services based on the price you'll pay and quality of care.
- See personalized cost estimates based on your location, your health plan, and whether or not you've already paid your deductible.
- Review step-by-step explanations of past medical spending so you know how much you paid and why.

Castlight lists prices for doctors and services that have been used by state employees. Although all medical services may not have prices, the most common ones will, and new services are added every month.

Castlight lets all state medical plan members share the costs of their medical services in a completely anonymous and private way. In this way, members can help each other lower medical costs for themselves and the State by shopping for medical services.

Get started with Castlight today! Register at <https://mycastlight.com/stateofindiana>.

Who is an eligible dependent?

Open Enrollment is a good opportunity to double check the dependents enrolled in all of your plans with the state of Indiana. Make sure you have added eligible dependents to all the plans you intended including dental and vision. Conversely it is important that you remove all dependents that are no longer eligible or that you do not wish to cover during this time period. Beginning 2016 the definition of an eligible dependent is as follows:

“Dependent” means:

- (a) Spouse of an employee;
- (b) Any children, step-children, foster children, legally adopted children of the employee or spouse, or children who reside in the employee’s home for whom the employee or spouse has been appointed legal guardian or awarded legal custody by a court, under the age of twenty-six (26). Such child shall remain a “dependent” for the entire calendar month during which he or she attains age twenty-six (26).

In the event a child:

- i.) was defined as a “dependent”, prior to age 19, and
- ii.) meets the following disability criteria, prior to age 19:
 - is incapable of self-sustaining employment by reason of mental or physical disability,
 - resides with the employee at least six (6) months of the year, and
 - receives 50 percent of his or her financial support from the parent

Such child’s eligibility for coverage shall continue, if satisfactory evidence of such disability and dependency is received by the State or its third party administrator in accordance with disabled dependent certification and recertification procedures. Eligibility for coverage of the “Dependent” will continue until the employee discontinues his coverage or the disability criteria is no longer met. A Dependent child of the employee who attained age 19 while covered under another Health Care policy and met the disability criteria specified above, is an eligible Dependent for enrollment so long as no break in Coverage longer than sixty-three (63) days has occurred immediately prior to enrollment. Proof of disability and prior coverage will be required. The plan requires periodic documentation from a physician after the child’s attainment of the limiting age.

For the 2016 benefit plan year, Anthem will administer the disabled dependent verification process for the State’s medical, dental and vision plans. Anthem will request verification of disability for your dependent(s) in early 2016 in order to determine eligibility to continue coverage under your health plan(s). **Please note:** the language regarding disabled dependent has been expanded.

If you have questions or concerns about dependent coverage, please feel free to contact State Personnel at 1-877-248-0007 outside the 317 area code or 317-232-1167 locally.

Continue to engage with HumanaVitality

Whether you attained Silver Status by August 31 or not, continue to engage with HumanaVitality! The health and wellness benefits from the program run far beyond the qualification deadline. As you continue to engage with HumanaVitality, you can keep increasing your Vitality Status by earning more points and bucks throughout the remainder of the year! As your Vitality Status increases, so does the discount you receive in the HumanaVitality mall. You may redeem your Vitality Bucks through the mall for cool prizes such as fitness devices, bikes, gift cards and much more!

A few things to keep in mind as you continue to earn Vitality Points and Bucks while the New Year approaches:

- 10 percent of your total points at the end of the year will rollover to 2016. This means that the more you do this year, the easier qualifying could be for you next year!
- Any unused Vitality Bucks stay with you into 2016 and beyond! Vitality Bucks expire three years from the end of the program year in which they were earned. For example, any unused Vitality Bucks earned in 2015 stay with you until year’s end in 2018, assuming you are still enrolled in HumanaVitality.
- Do you enjoy receiving a 10 percent, 20 percent, or 40 percent discount in the HumanaVitality Mall with your Vitality Bucks? This is all dependent on your reward status, which will rollover with you in 2016, once you have completed the Health Assessment in the New Year! You may check your reward status by scrolling over “Get Healthy” and clicking on “Achievement Dashboard.”

**Not signed up for HumanaVitality?
See page 14**

For Eligible Participants: HIP Link Power account vs. Health Savings Accounts

Enrolling in the state’s new HIP Link program allows members to receive assistance for the cost of health insurance. HIP Link is an innovative new part of the Healthy Indiana Plan that helps cover a portion of the member’s health insurance costs and out-of-pocket medical expenses (copayments for office visits, deductibles) when they enroll in their employer’s health plan. This is accomplished with a \$4,000 Personal Wellness and Responsibility (POWER) account that is similar to a Health Savings Account (HSA). Eligible employees who would like to enroll in HIP Link but who already have an existing balance in an HSA can keep the HSA open and continue to use the funds available to pay for eligible medical expenses even after enrolling in HIP Link. However, to avoid possible tax penalties, HIP Link members cannot receive employer contributions or add funds to their HSA while enrolled in HIP Link.

The following table provides a brief summary of the HIP Link POWER Account as compared to the State’s HSA:

HIP Link POWER Account	HSA
✓ \$4,000 per member annually available to cover a portion of premium cost and medical expenses.	✓ \$599 - \$2500 contributed by the State to use for eligible medical expenses.
✓ Keep existing account and balance in an HSA if already opened that can be used for eligible medical expenses.	✓ Use balance to pay for eligible medical expenses.
✓ Unused contributions may help reduce costs in next year’s enrollment.	✓ Unused dollars remain in the account and are yours to use for qualified expenses even after employment ends.

To enroll in HIP Link, simply call 1-800-403-0864. For questions about the program or this message, contact Sara Hall at 317-234-8030. If you are not currently enrolled in a medical plan provided by SPD, but qualify for HIP Link, you may enroll in coverage during the open enrollment period for

coverage effective January 1, 2016.

If you would like more information about HIP Link, go to www.in.gov/fssa/hip/2489.htm. You may also call 1-877-GET-HIP-9 to learn more about your options and receive counseling to help you determine what health coverage option is best for you.

Start now! Sign up for HumanaVitality today

HumanaVitality, an incentive based wellness program, empowers people with the tools necessary to reach their optimal health. By participating in health-related activities that can be tracked and measured, such as taking wellness classes, exercising and getting regular medical check-ups and screenings, members earn Vitality Points which are used to determine their Vitality Status. Members earn a Vitality Buck for every Vitality Point earned, which they can redeem for products, services and discounts with HumanaVitality’s preferred partners. HumanaVitality is available to employees (and their covered dependents) enrolled in a medical plan offered through the State Personnel Department.



Activating a membership is simple! Visit our.humana.com/investinyourhealth/ and follow these steps:

1. Click the green “sign in or register” button and then “register now as a new user” link.
2. Click “Get Started” button.
3. Under the green Registration heading, there are three tabs. Choose the far right tab titled “All other members”. If you do not have your Humana ID card yet, you can enter your birth date and social security number

- to finish the registration.
- Dependents/Spouses: have them create an account as well! They will have a different Humana ID number than the plan holder. If they do not know their Humana ID, you can use their birth date and social security number instead.
- 4. You can also set up your account by downloading the HumanaVitality mobile app from your mobile device app store.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “especial Enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949

COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: https://www.flmedicaidprecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100

MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
<p>Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739</p>	<p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p>
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>	<p>Website: http://www.insureoklahoma.org Phone: 1-888-365-3742</p>
MONTANA – Medicaid	OREGON – Medicaid
<p>Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084</p>	<p>Website: http://www.oregonhealthykids.gov http://www.hijosaludablesoregon.gov Phone: 1-800-699-9075</p>
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
<p>Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633</p>	<p>Website: http://www.dhs.state.pa.us/hipp Phone: 1-800-692-7462</p>
NEVADA – Medicaid	RHODE ISLAND – Medicaid
<p>Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900</p>	<p>Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300</p>
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
<p>Website: http://www.scdhhs.gov Phone: 1-888-549-0820</p>	<p>Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282</p>

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)



YOUR RIGHTS UNDER USERRA

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

REEMPLOYMENT RIGHTS

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- ☆ you ensure that your employer receives advance written or verbal notice of your service;
- ☆ you have five years or less of cumulative service in the uniformed services while with that particular employer;
- ☆ you return to work or apply for reemployment in a timely manner after conclusion of service; and
- ☆ you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

RIGHT TO BE FREE FROM DISCRIMINATION AND RETALIATION

If you:

- ☆ are a past or present member of the uniformed service;
- ☆ have applied for membership in the uniformed service; or
- ☆ are obligated to serve in the uniformed service;

then an employer may not deny you:

- ☆ initial employment;
- ☆ reemployment;
- ☆ retention in employment;
- ☆ promotion; or
- ☆ any benefit of employment

because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

HEALTH INSURANCE PROTECTION

- ☆ If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- ☆ Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

ENFORCEMENT

- ☆ The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- ☆ For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its **website at <http://www.dol.gov/vets>**. An interactive online USERRA Advisor can be viewed at **<http://www.dol.gov/elaws/userra.htm>**.
- ☆ If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.
- ☆ You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the internet at this address: <http://www.dol.gov/vets/programs/userra/poster.htm>. Federal law requires employers to notify employees of their rights under USERRA, and employers may meet this requirement by displaying the text of this notice where they customarily place notices for employees.



U.S. Department of Labor
1-866-487-2365

U.S. Department of Justice Office of Special Counsel

1-800-336-4590

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